		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022996

Facility Name: Iona Glos SLC

Address: 2801 Finley Road (Number) Downers Grove (City) 60515 (Zip Code)

County: DuPage

Telephone Number: (630) 620-2222 **Fax #** (630) 628-2350

IDPA ID Number: 36-2411166-001

Date of Initial License for Current Owners: 11/18/90

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kathy Francis **Telephone Number:** (630) 620-2222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) William K. Murphy
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: no change

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,600	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	35,771			35,771	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,771			35,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.73%

D. How many bed-hold days during this year were paid by Public Aid? 829 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/11/80

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	133,722		12,918	146,640		146,640		146,640			1
2	Food Purchase		245,947		245,947		245,947		245,947			2
3	Housekeeping		96,212	59,999	156,211		156,211	(4)	156,207			3
4	Laundry											4
5	Heat and Other Utilities			110,917	110,917		110,917	(52)	110,865			5
6	Maintenance	53,878	64,941		118,819	375	119,194	(9)	119,185			6
7	Other (specify):* waste removal			12,246	12,246		12,246		12,246			7
8	**TOTAL General Services**	187,600	407,100	196,080	790,780	375	791,155	(65)	791,090			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	488,405	59,885	24,661	572,951		572,951		572,951			10
10a	Therapy	1,614,388		47,069	1,661,457		1,661,457		1,661,457			10a
11	Activities	66,651	15,546		82,197	44	82,241	(170)	82,071			11
12	Social Services	31,416			31,416		31,416		31,416			12
13	Nurse Aide Training	13,391	3,250		16,641		16,641		16,641			13
14	Program Transportation	55,577		15,436	71,013	2,022	73,035		73,035			14
15	Other (specify):* license/cert&sch XVIII		458	26,575	27,033	7	27,040		27,040			15
16	**TOTAL Health Care and Programs**	2,269,828	79,139	113,741	2,462,708	2,073	2,464,781	(170)	2,464,611			16
	C. General Administration											
17	Administrative	361,832			361,832		361,832	(14,330)	347,502			17
18	Directors Fees											18
19	Professional Services			37,930	37,930	133	38,063	(4,707)	33,356			19
20	Dues, Fees, Subscriptions & Promotions			22,355	22,355	(222)	22,133	(2,224)	19,909			20
21	Clerical & General Office Expenses	250,904	65,343		316,247	(319)	315,928	(1,673)	314,255			21
22	Employee Benefits & Payroll Taxes			495,716	495,716	218	495,934	(1,586)	494,348			22
23	Inservice Training & Education			7,746	7,746	(1,004)	6,742	(22)	6,720			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,124	2,124		2,124	(634)	1,490			25
26	Insurance-Prop.Liab.Malpractice			45,515	45,515		45,515	(82)	45,433			26
27	Other (specify):* see worksheet 3			13,381	13,381	1,633	15,014	(11,018)	3,996			27
28	**TOTAL General Administration**	612,736	65,343	624,767	1,302,846	439	1,303,285	(36,276)	1,267,009			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,070,164	551,582	934,588	4,556,334	2,887	4,559,221	(36,511)	4,522,710			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Iona Glos SLC #0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			151,396	151,396		151,396	131,822	283,218			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,877	16,877	23	16,900		16,900			32
33	Real Estate Taxes			895	895		895		895			33
34	Rent-Facility & Grounds			59,245	59,245	(886)	58,359	(2,344)	56,015			34
35	Rent-Equipment & Vehicles			34,686	34,686	(2,024)	32,662	(4,704)	27,958			35
36	Other (specify):*											36
37	**TOTAL Ownership**			263,099	263,099	(2,887)	260,212	124,774	384,986			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,888	7,888		7,888		7,888			41
42	Provider Participation Fee			282,464	282,464		282,464		282,464			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			290,352	290,352		290,352		290,352			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,070,164	551,582	1,488,039	5,109,785		5,109,785	88,263	5,198,048			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,159	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(115)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,916)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see page 5A	(35,911)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,783)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	109,046		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 109,046		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 88,263		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Iona Glos SLC

ID# **0022996**

Report Period Beginning: **07/01/99**

Ending: **06/30/00**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjustment for Fund Raising = 25% of Public	$		1
2	Development - also see worksheet 1			2
3	Supplies	(4)	3	3
4	Utilities	(52)	5	4
5	Maintenance	(9)	6	5
6	Activities	(170)	11	6
7	Salaries	(12,067)	17	7
8	Professional Services	(5)	19	8
9	Publications	(118)	20	9
10	Membership Dues	(129)	20	10
11	Clerical & General Office Expense	(1,673)	21	11
12	Employee Benefits and Payroll Taxes	(1,586)	22	12
13	Staff Training	(22)	23	13
14	Travel	(105)	25	14
15	Insurance	(82)	26	15
16	Miscellaneous	(59)	27	16
17	Agency Functions	(829)	27	17
18	Depreciation	(196)	30	18
19	Rent	(2,344)	34	19
20	Equipment Rental	(258)	35	20
21	Total Fund Raising Adjustment	(19,708)		21
22				22
23	Other Non-Allowables and Adjustments			23
24	Administrative Other Compensation	(2,263)	17	24
25	Non-Care Related Legal and Professional Services	(4,702)	19	25
26	Non-Care Related Membership Dues	(1,977)	20	26
27	Non-Care Related Administrative Travel	(529)	25	27
28	Non-Care Related Miscellaneous	(97)	27	28
29	In & Out	505	27	29
30	Agency Functions	(5,507)	27	30
31	Total Other Non-Allowables and Adjustments	(1,633)	35	31
32		(16,203)		32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(35,911)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Iona Glos SLC # 0022996 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(4)	0	0	0	0	0	0	0	0	0	0	(4)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(52)	0	0	0	0	0	0	0	0	0	0	(52)	5
6	Maintenance	(9)	0	0	0	0	0	0	0	0	0	0	(9)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(65)	0	0	0	0	0	0	0	0	0	0	(65)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(170)	0	0	0	0	0	0	0	0	0	0	(170)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(170)	0	0	0	0	0	0	0	0	0	0	(170)	16
	C. General Administration													
17	Administrative	(14,330)	0	0	0	0	0	0	0	0	0	0	(14,330)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,707)	0	0	0	0	0	0	0	0	0	0	(4,707)	19
20	Fees, Subscriptions & Promotions	(2,224)	0	0	0	0	0	0	0	0	0	0	(2,224)	20
21	Clerical & General Office Expenses	(1,673)	0	0	0	0	0	0	0	0	0	0	(1,673)	21
22	Employee Benefits & Payroll Taxes	(1,586)	0	0	0	0	0	0	0	0	0	0	(1,586)	22
23	Inservice Training & Education	(22)	0	0	0	0	0	0	0	0	0	0	(22)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(634)	0	0	0	0	0	0	0	0	0	0	(634)	25
26	Insurance-Prop.Liab.Malpractice	(82)	0	0	0	0	0	0	0	0	0	0	(82)	26
27	Other (specify):*	(11,018)	0	0	0	0	0	0	0	0	0	0	(11,018)	27
28	**TOTAL General Administration**	(36,276)	0	0	0	0	0	0	0	0	0	0	(36,276)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,511)	0	0	0	0	0	0	0	0	0	0	(36,511)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Iona Glos SLC** **#** **0022996** **Report Period Beginning:** **07/01/99** **Ending:** **06/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	19,963	111,859	0	0	0	0	0	0	0	0	0	131,822	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,344)	0	0	0	0	0	0	0	0	0	0	(2,344)	34
35	Rent-Equipment & Vehicles	(1,891)	(2,813)	0	0	0	0	0	0	0	0	0	(4,704)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	15,728	109,046	0	0	0	0	0	0	0	0	0	124,774	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,783)	109,046	0	0	0	0	0	0	0	0	0	88,263	45

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Not for Profit Corp - board members DO NOT have ownership in the Ray Graham Association or the Ray Graham Foundation				Ray Graham Foundation	Downers Grove, IL	social service
see attached list of board of directors						foundation
no board members directly provided service to the SLC						
no board members have ownersship in any entity that conducted buseness transactions with the SLC						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	35	vehicle lease	$ 2,813	Ray Graham Foundation		$	$ (2,813)	1
2	V								2
3	V	30	building depreciation		Ray Graham Foundation		104,706	104,706	3
4	V								4
5	V	30	equipment depreciation		Ray Graham Foundation		7,153	7,153	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,813			$ 111,859	$ * 109,046	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	none										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Ray Graham Foundation
Street Address: 2801 Finley Road
City / State / Zip Code: Downers Grove, IL 60532
Phone Number: (630) 620-2222
Fax Number: (630) 628-2350

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see worksheet 1				$ 2,205,845	$ 1,166,027		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,205,845	$ 1,166,027		$	25

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Old Kent Leasing (Vanguard)		x	Phone System Capital Lease	$248.00	6/15/95	$ 10,969	$	6/15/00	0.1320	$ 172	1
2	Lucent Technologies Product		x	Phone System - Admin	$967.00	7/1/97	50,369	21,879	7/1/02	0.0560	1,559	2
3	American National Bank		x	Computers - Admin	$757.00	12/24/98	24,176	12,827	12/30/01	0.0775	1,346	3
4	totals				$1,972.00		$85,514.00	$34,706.00			$3,077.00	4
5	SLC allocation = .273589				$540.00		$23,396.00	$9,495.00			$842.00	5
	Working Capital											
6	allocated - see worksheet 6			operating funds	n/a		142,153	142,153			16,058	6
7	NOTE:COL 4 LINE 9 AMOUNT											7
8	WRONG DUE TO PROTECTION											8
9	TOTAL Facility Related				$4,484.00		$ 165,549	$ 151,648			$ 16,900	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 165,549	$ 151,648			$ 16,900	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	292	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	890	2
3. Under or (over) accrual (line 2 minus line 1).	$	598	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	297	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	895	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	961	8
	1996	972	9
	1997	305	10
	1998	310	11
	1999	886	12

2. 1/2 of 1998 = 447 and 1/2 of 1999 = 443

4. 1/2 of 1999 bill = 443 less half of 1999 accrual = 146

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,000 B. General Construction Type: Exterior brick Frame _____ Number of Stories one

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [x] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1990	$ 214,674	1
2					2
3	TOTALS			$ 214,674	3

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1981	1981	$ 3,681,931	$ 92,048	40	$ 92,048	$	$ 1,794,941	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Fiscal Years			1994	19,465	1,946	5	1,946		19,465	9
10				1995	65,882	11,921	3-5	11,921		59,954	10
11				1996	244,469	48,685	3-5	48,685		184,366	11
12				1997	222,002	44,740	3-5	44,740		156,253	12
13				1998	48,805	9,678	3-5	9,678		19,064	13
14											14
15	Allocated from Administration - air conditioning			2000	48,600	2,430	10	2,430		230	15
16	sprinkler heads			1999	855	43	10	43		43	16
17	total adiministration			1999	49,455	2,473		2,473		273	17
18	SLC alloaction = .273589				13,530	677		677		75	18
19											19
20	From Ray Graham Foundation										20
21	from Prior Fiscal Years				59,303	7,050	5 to 10	7,050		10,574	21
22	kitchen remodeling in homes 2 & 5			1999	613	31	10	31		31	22
23	kitchen countertops in all homes			1999	19,475	974	10	974		974	23
24	compressor			1999	3,154	158	10	158		158	24
25	hot water heater			1999	4,550	228	10	228		228	25
26	carpeting in core building			1999	3,959	193	10	193		193	26
27	home 6 baths renovation iclude replace all fixtures, flooring, drywall			1999	19,875	870	10	870		870	27
28	home 1 tub room renovation including hydrolic lift tub installed, new			1999	14,050	703	10	703		703	28
29	tile on floor and walls, painting and new light fixtures										29
30	home 4 tub room renovation including same work as home 1 above			1999	14,220	711	10	711		711	30
31	alarm			1999	2,411	121	10	121		121	31
32	carriage lock			1999	1,808	90	10	90		90	32
33	replace sidewalks			2000	9,400	470	10	470		470	33
34	condensor			2000	2,185	109	10	109		109	34
35	2 bath tubs			2000	19,046	952	10	952		952	35
36	TOTAL (lines 4 thru 35)				$ 4,470,133	$ 222,355		$ 222,355	$	$ 2,250,302	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	THIS IS REALLY PAGE 13 A - EQUIPMENT DEPRECIATION										9
10	SLC Direct -										10
11	Purchased in Prior Years										11
12	SLC				104,463	20,046	3 to 10	20,046		71,847	12
13	Clinical				5,635	1,612	3 to 5	1,612		4,227	13
14	SLC allocation - .040000				225	64		64		169	14
15	Consumer Advocacy				1,987	319	5	319		1,695	15
16	SLC allocation -.273586				543	87		87		464	16
17	Intake				622	124	5	124		372	17
18	SLC allocation -.020000				12	2		2		7	18
19											19
20											20
21											21
22	Current Year Purchases										22
23	SLC				1,061		5	106	106	106	23
24											24
25											25
26											26
27											27
28	Fully Depreciated										28
29	SLC				458,667					458,667	29
30	Transportation				50,795					50,795	30
31	SLC allocation - .041300				2,098					2,098	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 567,069	$ 20,199		$ 20,305	$ 106	$ 533,358	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	THIS IS REALLY PAGE 13 B - EQUIPMENT DEPRECIATION										9
10	Management and General -										10
11	Purchased in Prior Years										11
12	Administration				166,481	33,030	3 to 5	34,975	1,945	96,743	12
13	SLC allocation - .273589				45,548	9,036		9,602	566	26,468	13
14											14
15	Current Year Purchases										15
16	Administration										16
17	6 Dell PCs			1999	7,780	778	5	778		778	17
18	billing system software			1999	769	77	5	77		77	18
19	fireproof safe			2000	659	66	5	66		66	19
20	fax, printer			1999	694	69	5	69		69	20
21	phone system expansion			1999	4,217	422	5	422		422	21
22	13 UPS units			1999	5,474	547	5	547		547	22
23	PC hub			1999	762	76	5	76		76	23
24	Best fixed assets softeeware			2000	649	65	5	65		65	24
25	cabling			2000	636	64	5	64		64	25
26	central stores inventory cage			2000	1,185	119	5	119		119	26
27	laser printer			1999	1,622	162	5	162		162	27
28	total Administration				24,447	2,445		2,445		2,445	28
29	SLC allocation - .273589				6,688	669		669		669	29
30											30
31	Fully Depreciated										31
32	Administration				269,998					269,998	32
33	SLC allocation - .273589				73,868					73,868	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 126,104	$ 9,705		$ 10,271	$ 566	$ 101,005	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	THIS IS REALLY PAGE 13 C - EQUIPMENT DEPRECIATION										9
10	Ray Graham Foundation										10
11	Purchased in Prior Years										11
12	Administration				111,817	20,914	5 to 7	20,914		97,321	12
13	SLC allocation - .273589				30,592	5,722		5,722		26,626	13
14											14
15											15
16	Current Year Purchases										16
17	SLC										17
18	widow treatments for home#5			1999	1,600	229	7	229		343	18
19	gas range for kitchen			1999	4,502	450	5	450		450	19
20	refridgerator - home #5			1999	911	91	5	91		91	20
21	refridgerator - home #2			1999	980	98	5	98		98	21
22	2 microwaves, 2 tap ranges			1999	2,326	233	5	233		233	22
23	water heater for home #3			2000	3,304	330	5	330		330	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 44,215	$ 7,153		$ 7,153	$	$ 28,171	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 181,383	$ 34,957	$ 35,523	$ 566		$ 125,581	37
38	Current Year Purchases	21,372	2,100	2,206	106		2,320	38
39	Fully Depreciated Assets	534,633					534,633	39
40	also see pages 12A,12B,12C/13A,13B,13C							40
41	TOTALS	$ 737,388	$ 37,057	$ 37,729	$ 672		$ 662,534	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	client transportation	1992 Ford Econoline	1995	$ 6,654	$ 1,331	$ 1,331	$	5	$ 6,432	42
43	client transportation	1997 Dodge MiniVan	1997	35,401	7,080	7,080		5	24,781	43
44	client transportation	1998 Dodge Van	1998	36,417	7,283	7,283		5	10,925	44
45	client transportation	1999 Dodge Van	1999	37,203	7,441	7,441		5	11,161	45
46	TOTALS			$ 115,675	$ 23,135	$ 23,135	$		$ 53,299	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,537,870	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 282,547	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 283,219	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 672	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,966,135	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	NONE	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	NONE	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Stojka Brothers Partnership and Real Estate Opportunity Corp - see worksheet 8

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		n/a	10/15/98	$ 6,193	5	n/a	3
4	Additions		n/a	01/27/98	49,822	6	n/a	4
5					see worksheet 7			5
6								6
7	TOTAL				$ 56,015 **			7

8. List separately any amortization of lease expense included on page 4, line 34. n/a
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 10/15/98 & 02/26/98
Ending 10/14/03 & 02/25/04

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2001	$ 55,209
13.	6/30/2002	$ 55,400
14.	6/30/2003	$ 55,597

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 27,958 Description: see worksheet 8
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	NONE		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	40
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	80
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$ 1,163	$ 1,662	$	$ 2,825
2	Books and Supplies		175	250		425
3	Classroom Wages	(a)	1,545	2,916		4,461
4	Clinical Wages	(b)	3,098	5,832		8,930
5	In-House Trainer Wages	(c)	3,841	7,248		11,089
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 9,822	$ 17,908	$	$ 27,730
10	SUM OF line 9, col. 1 and 2	(e)	$ 27,730			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	17

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	NONE	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 106,903	$	1
2	Cash-Patient Deposits	131,369		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 101,841)	1,268,944		3
4	Supply Inventory (priced at cost)	26,900		4
5	Short-Term Investments			5
6	Prepaid Insurance	99,550		6
7	Other Prepaid Expenses	44,656		7
8	Accounts Receivable (owners or related parties)	87		8
9	Other(specify): security deposits	36,070		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,714,479	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,531,412		15
16	Equipment, at Historical Cost	2,353,575		16
17	Accumulated Depreciation (book methods)	(3,154,499)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 730,488	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,444,967	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 734,795	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	131,369		28
29	Short-Term Notes Payable	532,411		29
30	Accrued Salaries Payable	739,365		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,824		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,643		32
33	Accrued Interest Payable			33
34	Deferred Compensation	52,330		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	capital lease obligations	21,879		36
37	deferred income	56,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,322,116	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,731		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 32,731	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,354,847	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 90,120	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,444,967	$	48

***(See instructions.)**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4	NOT APPLICABLE		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(45,350)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (45,350)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (45,350)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,892,267	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,892,267	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,225	10
11	Nurses Aide Training Reimbursements	20,086	11
12	Gift and Coffee Shop	8,989	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 31,300	23
	D. Non-Operating Revenue		
24	Contributions	118,424	24
25	Interest and Other Investment Income***	70	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 118,494	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	see worksheet 9	22,374	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,374	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,064,435	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	790,780	31
32	Health Care	2,462,708	32
33	General Administration	1,302,846	33
	B. Capital Expense		
34	Ownership	263,099	34
	C. Ancillary Expense		
35	Special Cost Centers	7,888	35
36	Provider Participation Fee	282,464	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,109,785	40
41	**Income before Income Taxes (line 30 minus line 40)****	(45,350)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (45,350)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,762	1,850	39,114	21.14	3
4	Licensed Practical Nurses	14,678	14,682	247,855	16.88	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	1,837	1,837	13,391	7.29	6
7	Licensed Therapist	1,261	1,344	26,288	19.56	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,548	6,542	66,651	10.19	10
11	Social Service Workers	1,279	1,279	31,416	24.56	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,035	29,345	14.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,868	11,856	104,378	8.80	15
16	Dishwashers					16
17	Maintenance Workers	4,240	4,236	53,878	12.72	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,105	52,796	25.08	20
21	Assistant Administrator	2,058	2,080	37,293	17.93	21
22	Other Administrative	13,309	13,296	143,836	10.82	22
23	Office Manager					23
24	Clerical	5,604	5,964	59,799	10.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	12,779	12,743	201,436	15.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	169,790	165,961	1,588,100	9.57	30
31	Medical Records					31
32	Other Health C: drivers	5,675	5,671	55,577	9.80	32
33	Other(specify) M&G-see wks 2	16,022	15,991	319,012	19.95	33
34	TOTAL (lines 1 - 33)	272,827	269,472	$ 3,070,165 *	$ 11.39	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	323	$ 12,918	1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	154	5,843	10a	40
41	Occupational Therapy Consultant	344	16,856	10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	609	24,370	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) psychiatrist	57	10,055	15	46
47	physician	monthly	16,500	15	47
48	temporary clerical plus code error $14	5	20	15	48
49	TOTAL (lines 35 - 48)	1,492	$ 86,562		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	12	$ 547	10	50
51	Licensed Practical Nurses	754	24,113	10	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	766	$ 24,660		53

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
see worksheet 10			361,832
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 361,832

B. Administrative - Other

Description	Amount
none	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
see worksheet 2		37,930
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 37,930

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,174
Unemployment Compensation Insurance	10,462
FICA Taxes	226,584
Employee Health Insurance	189,966
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan = 70 employees	15,179
Tuition Reimbursement	7,485
Employee Incentives	215
Employee Assistance Program	4,284
TOTAL (agree to Schedule V, line 22, col.8)	$ 494,349

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
none		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,417
Health Care Worker Background Check	1,675
(Indicate # of checks performed 99)	
publications	1,064
memberships	563
other recruitment expenses:	
employee referals	808
job fairs	390
pre-employment physiclas	1,992
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,909

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
none	
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	none												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Iona Glos SLC # 0022996 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? no

(2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 12,314 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 282,464
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ n/a Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Miller, Cooper & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.